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Supreme Court, U.S.
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No. 03-1203

IN THE

Supreme Court of the United States

RELIANCE STANDARD LIFE INSURANCE COMPANY,

Petitioner,

v.

STEPHEN P. LASSER,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

RESPONDENT'S BRIEF IN OPPOSITION

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COUNTERSTATEMENT OF QUESTIONS PRESENTED

1. Whether, as this Court suggested in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989), in an action under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001-1461, a court may consider as a factor in conducting arbitrary-and-capricious review of an administrator's discretionary decision to deny benefits that the administrator is also the plan insurer and thus operates under a structural conflict of interest.

2. Whether, for purposes of all disability insurance policies subject to ERISA, a claimant's return to work out of economic necessity is, as a matter of law, dispositive evidence that the claimant is not disabled.

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INTRODUCTION

Petitioner, Reliance Standard Life Insurance Company ("Reliance"), has not presented any question that merits the Court's attention. Reliance argues that the Court should address the degree of deference to be afforded to an administrator of an ERISA-covered disability insurance plan which, because it also is the insurer under the plan, operates under a structural conflict of interest in making discretionary decisions on eligibility for benefits. Reliance did not raise this issue in the Third Circuit, however. Specifically, it did not challenge the district court's ruling, in light of the carrier's structural conflict, to accord it a "moderate degree of deference" (Pet. App. 42a) under an arbitrary-and-capricious standard of review. For this reason alone, the petition should be denied on the first question presented. This case is also a poor vehicle for deciding the standard-of-review question presented by Reliance. As the district court noted, it is "an academic exercise" (Pet. App. 74a) to decide what standard of review should apply here because Reliance's decision to deny Dr. Lasser's claim for disability benefits would be erroneous under any standard of review.

In any event, there is simply *no* conflict among the circuits on the standard-of-review question in this case. All of the courts of appeals to have addressed this question agree, consistent with this Court's statement in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989), that a plan administrator's conflict of interest is a factor to be considered in conducting arbitrary-and-capricious review where the administrator's discretionary denial of benefits under the plan does not reflect any actual bias.

Reliance's second question presented is whether a claimant's return to work is, as a matter of law, dispositive of non-disability in all settings. The Court of Appeals rejected Reliance's argument for case-specific reasons, namely, that Dr. Lasser returned to work out of economic necessity, to the detriment of his health, and against medical advice. To

create the appearance of a circuit split, Reliance cites two decisions where the policy language at issue expressly provided that a claimant could not be deemed disabled if he was working. There is no such language in the policy at issue here. The cases offered by Reliance thus merely underscore the unremarkable proposition that courts look to policy-specific language and case-specific evidence of a claimant's disability in evaluating an insurer's determination against disability.

STATEMENT OF THE CASE

Dr. Lasser's Disability and Claim for Benefits

Dr. Lasser is an orthopedic surgeon who was employed by a four-doctor practice group in New Jersey. Pet. App. 5a. He has coronary artery disease and, due to a progression in his disease and a bypass surgery in 1986 that was improperly performed, suffered a heart attack in July 1996. *Id.* at 6a. After the heart attack, Dr. Lasser's treating physician advised him to reduce his work-related stress. *Id.* In accordance with this advice, Dr. Lasser returned to work in September 1996 on a reduced schedule. *Id.* He decreased his patient load by 50%, was no longer "on call" at night or on weekends, and did not perform emergency surgery. *Id.* As a result of his decreased work schedule, Dr. Lasser's compensation fell from approximately $26,000 per month to between $4,000 and $6,000 per month. *Id.* at 12a.[1]

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[1] Reliance states in its petition that a claimant is "disabled" under the policy, and thus entitled to disability benefits, "if he or she is not 'capable of performing the material duties of his/her regular occupation' on *a full-time basis*." Pet. 3 (emphasis added). This is *not* what the policy states. Under the policy, a claimant is considered totally disabled if he or she "is capable of performing the material duties of his/her regular occupation on a *part-time basis* or some of the material duties on a full-time basis." Pet. App. 42a (emphasis added). Dr. Lasser's return to part-time work in September 1996 thus did not render him ineligible for disability benefits under his policy.

Reliance had issued a long-term disability policy to Dr. Lasser's practice group. Pet. App. 5a-6a. Dr. Lasser made an application for long-term disability benefits under this policy. On December 26, 1996, Reliance initially granted the application, *id.* at 6a, but then changed its mind one year later, primarily in response to a medical evaluation by a Dr. William Burke hired by Reliance. *Id.* Dr. Burke concluded that Dr. Lasser was not disabled because he had performed well on a treadmill test and certain other physical tests. *Id.* at 15a; *see also id.* at 43a-44a. Dr. Burke's report did not, however, address the risks posed to Dr. Lasser by work-related stress, as identified by Dr. Lasser's treating physician. *Id.* at 43a-46a.

Dr. Lasser invoked Reliance's appeal procedure to challenge the carrier's termination of benefits. Pet. App. 6a. A total of five cardiologists other than Dr. Burke—including two whom Reliance itself had specifically retained after Dr. Lasser initiated his appeal—examined Dr. Lasser and concluded that due to his heart condition he should avoid work-related stress and, in particular, should not perform all of his customary duties as an orthopedic surgeon. *Id.* at 16a-19a; *see also id.* at 44a, 56a. Reliance nevertheless denied Dr. Lasser's administrative appeal and determined that Dr. Lasser was not "disabled" within the meaning of the policy. *Id.* at 7a.

Proceedings in the District Court

Dr. Lasser brought this lawsuit to challenge Reliance's denial of benefits to him under ERISA's private-action provision, which allows a beneficiary to sue for "benefits due to him under the terms of his plan." 29 U.S.C. § 1132(a)(1)(B). Pet. App. 7a. The parties made cross motions for summary judgment. *Id.* at 78a. The district court denied both motions. *Id.* at 103a-104a.

After a bench trial, the district court determined what standard of review to apply. Pet. App. 38a-42a. Finding that Reliance operated under a structural conflict of interest yet

exhibited no "overt bias" in denying Dr. Lasser's claim, the court ruled that the appropriate standard in this case was a modified form of arbitrary-and-capricious review under which Reliance was afforded a "moderate degree of deference." *Id.* at 42a.

The district court then held that Reliance abused its discretion by failing to provide a rational explanation for why it discounted the substantial weight of medical opinion—specifically, the opinions of Dr. Lasser's treating cardiologist and three other cardiologists—that Dr. Lasser could not return to full-time work without unduly increasing the risk of suffering another heart attack. Pet. App. 56a. Instead, in denying Dr. Lasser's claim, Reliance adhered to Dr. Burke's analysis, which concluded that Dr. Lasser had performed well on certain physical tests and therefore was not disabled. *Id.* at 43a-44a. As the district court noted, five other cardiologists who had examined Dr. Lasser pointed out that Burke failed to address the risk to Dr. Lasser's condition posed by occupational stress.[2] *Id.* at 44a-46a. The court found that Dr. Burke's fundamental error "infected Reliance's entire treatment of the case," which included using a classification system that measured a cardiac patient's capacity for exercise but did not address occupational stress. *Id.* at 46a-47a.

The district court ordered judgment for Dr. Lasser. It held that Reliance had not "furnish[ed] sufficient grounds to uphold [its] decision under the arbitrary and capricious standard." Pet. App. 76a. And, although the court had applied a "slightly less deferential standard" to Reliance's decision, it determined that the carrier's decision was "so

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[2] The other cardiologists also faulted Dr. Burke for using an unconventional stress test that was not widely accepted and which, in one cardiologist's view, "raise[d] a question about the qualifications of [Dr. Burke]." Pet. App. 44a. The district court also catalogued other key errors and omissions in Dr. Burke's analysis. *Id.* at 44a-45a.

wrong as to require reversal under any standard." *Id.* at 41a. Indeed, the court stated that its application of the sliding-scale approach to this case was, in the end, "an academic exercise" because, "even under its most deferential iteration, arbitrary and capricious review requires that the denial of Dr. Lasser's benefits be reversed." *Id.* at 74a; *see also id.* at 76a ("[E]ven under the regular arbitrary and capricious standard, the decision must be reversed.").

Proceedings in the Court of Appeals

On appeal, the Third Circuit affirmed. Pet. App. 5a. At the outset of its decision, it briefly discussed the standard of review applicable to this case. *Id.* at 8a-9a. The court noted that in cases, such as this one, where an insurer of an ERISA plan also operates as a claims administrator, "there is a structural or inherent conflict of interest that mandates a 'heightened' arbitrary and capricious review" under the *Pinto* decision. *Id.* at 8a (quoting *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 378 (3d Cir. 2000)). The Court of Appeals then summarized the district court's ruling that "the correct standard of review was 'at the mild end of the heightened arbitrary and capricious scale.'" *Id.* at 9a. The appeals court did not review this ruling, however, because, as it noted, "*[n]either party* disputes this conclusion on appeal." *Id.* (emphasis supplied).

The Court of Appeals reviewed Reliance's determination that Dr. Lasser was not disabled under the arbitrary-and-capricious standard. It recounted the principal evidence cited by Reliance—Dr. Burke's report—and noted that Dr. Burke opined, on the basis of a treadmill test and a physical examination, that Dr. Lasser did not "demonstrate any cardiovascular disability." Pet. App. 15a (quoting Dr. Burke's report). It then summarized the reports of the five other cardiologists who had evaluated Dr. Lasser, each of whom addressed the impact of stress on Dr. Lasser's heart condition—a factor that Dr. Burke's report did not address (*id.* at 43a-48a)—and concluded that Dr. Lasser should avoid

the stress of performing emergency and on-call duties. *Id.* at 16a-19a. On the basis of the record considered as a whole, the Third Circuit agreed with the trial court that Reliance acted arbitrarily and capriciously by disregarding the findings of every evaluating physician except Dr. Burke—that Dr. Lasser's heart condition precluded him from safely performing on-call and emergency surgery duties. *Id.* at 19a.

Judge Garth dissented from the majority decision on several grounds, but he did not disagree with the district court's articulation of the standard of review. Pet. App. 23a-24a. Indeed, Judge Garth noted that, if an insurer operates under a structural conflict of interest but there is no proof of actual bias—as the district court found here—then "the standard of deference to be employed would be 'deferential, but not absolutely deferential.'" *Id.* at 23a-24a (quoting *Pinto*, 214 F.3d at 393). Judge Garth believed, however, that the district court failed to adhere to this concededly "correct standard of review." *Id.* at 25a.

After the Third Circuit panel issued its decision, Reliance filed a petition for rehearing and petition for rehearing *en banc*. Significantly, Reliance's petition did not challenge the Third Circuit's determination to apply a somewhat heightened form of arbitrary-and-capricious review in this case. Indeed, Reliance embraced the Third Circuit's underlying *Pinto* approach when it asserted that the panel majority's opinion "conflict[ed] with the law of this Circuit regarding the manner in which the court should review a plan's decision under the heightened arbitrary and capricious standard" and was "inconsistent with [*Pinto*'s] heightened arbitrary and capricious standard of review." Respondent's Appendix ("Resp. App.") 2a. The Third Circuit denied Reliance's petition, with Judge Garth dissenting. Pet. App. 1a-4a.

REASONS FOR DENYING THE PETITION

I. THE COURT SHOULD NOT GRANT THE WRIT ON THE STANDARD-OF-REVIEW QUESTION

A. The Standard-of-Review Question Was Never Raised Below

The issue of what is the appropriate standard to use in reviewing Reliance's denial of disability benefits to Dr. Lasser was not raised by Reliance in its appeal or in its petition for rehearing, and nor was it reached by the Third Circuit. As a general rule, *certiorari* is not granted on questions raised for the first time in a petition to this Court. *See TRW Inc. v. Andrews*, 534 U.S. 19, 34 (2001) (refusing to reach issue that was "not raised or briefed below"). "It is this Court's practice to decline to review those issues neither pressed nor passed upon below." *FW/PBS, Inc. v. City of Dallas*, 493 U.S. 215, 224 (1990).[3]

This rule operates to preclude Reliance's petition here. After noting that the *Pinto* decision's sliding scale "might, in the appropriate case, slide all the way back to fully deferential arbitrary and capricious review," Pet. App. 39a, the district court held that it was inappropriate to apply "unmodified" arbitrary and capricious review where an insurer labored under "a true, structural conflict, even where other indicia of conflict or bias are absent." *Id.* at 40a-41a.

On appeal, Reliance did not challenge the district court's ruling to review the evidence with a "moderate degree of deference." Pet. App. 42a. The Third Circuit expressly

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[3] *See also City of Springfield v. Kibbe*, 480 U.S. 257, 259 (1987) ("We ordinarily will not decide questions not raised or litigated in the lower courts."); *EEOC v. Fed. Labor Relations Auth.*, 476 U.S. 19, 24 (1986) (noting the Court's "normal practice" to "refrain from addressing issues not raised in the Court of Appeals"); *Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 147 n.2 (1970) ("Where issues are neither raised before nor considered by the Court of Appeals, this Court will not ordinarily consider them.").

observed that "*[n]either party* disputes this conclusion on appeal." *Id.* at 9a (emphasis added). And, in its rehearing *en banc* application, Reliance again did not argue that the district court chose the wrong standard of review and nor did it challenge the Third Circuit's sliding-scale approach first recognized by the *Pinto* panel decision. Reliance instead implicitly endorsed both *Pinto* and the district court's choice of standard. It argued that the majority opinion "conflicts with the law of *this Circuit*" and, citing *Pinto*, claimed that the majority opinion was "inconsistent with the heightened arbitrary and capricious standard of review." Resp. App. 2a (emphasis supplied).

Now, for the first time in the instant petition, Reliance seeks to raise an issue over the "choice of the appropriate standard of review" and says that that choice is "outcome-dispositive in this case." Pet. 15. As demonstrated below, resolution of this issue would make no difference to the outcome here. But, even if this issue mattered, Reliance has failed to preserve its ability to contest the choice of standard or review.

B. Resolution of the Standard-of-Review Question Would Make No Difference to the Outcome in This Case

A second reason this question is not cert-worthy is that the choice of standard of review would not affect the outcome here. The district court repeatedly stated that Reliance's denial of benefits to Dr. Lasser was erroneous and would require reversal even under an unmodified arbitrary and capricious standard. Pet. App. 41a ("[T]he denial of benefits was erroneous, and, indeed, so wrong as to require reversal *under any standard*.") (emphasis supplied); *id.* at 76a ("The Court believes that, even under the regular arbitrary and capricious standard, the decision must be reversed."). Indeed, the district court stated that it had been an "academic exercise" to determine the appropriate standard of review in this case because "*even under its most*

deferential iteration, arbitrary and capricious review requires that the denial of Dr. Lasser's benefits be reversed." *Id.* at 74a (emphasis supplied).

Because Reliance did not challenge the district court's choice of the standard of review, the Third Circuit assumed the denial of benefits was reviewable under the standard that the district court applied. Pet. App. 9a. But, as in the district court, whether the standard was garden-variety "arbitrary and capricious" or a somewhat heightened form of arbitrary-and-capricious review would not have made a difference to the result. The Court of Appeals held that Reliance's decision to deny benefits to Dr. Lasser was "arbitrary and capricious" and not supported by "substantial evidence," without itself referencing a heightened standard of arbitrary-and-capricious review. *Id.* at 15a, 21a. It would thus be, as the district court noted, an "academic exercise" for this Court to resolve the standard-of-review question presented in the petition.

Given this record, the premise of the petition is apparently not that the Court of Appeals used the wrong standard of review, but that it misapplied the concededly proper standard and "effectively applied *de novo* review." Pet. 1, 9; *see also id.* at 15. As an initial matter, Reliance is wrong; the Third Circuit properly applied the tenets of arbitrary-and-capricious review. Pet. App. 15a-19a (examining the "entire record to determine whether Reliance's determination is supported by substantial evidence"); *see also id.* at 21a.[4] In any event, Reliance must recognize that a petition complaining about the application of a proper standard to a particular state of facts is rarely granted. *See* S. Ct. R. 10 ("A petition for a writ of certiorari

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[4] The district court also properly invoked the principle of substantial-evidence review that a decision-maker may not adopt "what is so clearly the minority view [here, Dr. Burke's view] . . . without at least some rational explanation for doing so." Pet. App. 56a.

is rarely granted when the asserted error consists of . . . the misapplication of a properly stated rule of law."); *see also NLRB v. Hendricks Cty. Rural Elec. Membership Corp.*, 454 U.S. 170, 176 n.8 (1981) (questions of fact do not merit review by the Court); *Rudolph v. United States*, 370 U.S. 269, 270 (1962) (dismissing writ as improvidently granted where issue presented for review involved only the application of "clearly erroneous" standard of review).

C. There Is No Split Among the Courts of Appeals on the Standard-of-Review Question Presented by This Case

There is also no circuit split on the standard-of-review question identified (though not preserved) by Reliance. The question here is not, in general, what the standard of review should be in *any* action challenging a discretionary denial of benefits under an ERISA-covered plan when the administrator of the plan is also the insurer. Rather, the specific question as framed by the facts of this case is what the standard of review should be when an administrator's "structural" bias is not reflected by evidence of actual bias in its discretionary decision to deny benefits.

In this case, the district court expressly found that Reliance labored under a structural conflict of interest but that its claims administrator exhibited "no evidence of overt bias." Pet. App. 41a-42a. The courts of appeals are in full agreement as to what the appropriate standard of review should be in this circumstance: all circuits that have addressed the issue have held, consistent with this Court's statement in *Bruch*, that the administrator's determination should be reviewed under the arbitrary-and-capricious standard and that the administrator's inherent or structural conflict should be considered as a factor in conducting that review. *See generally Firestone*, 489 U.S. at 115 ("[I]f a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there

is an abuse of discretion.'") (quoting Restatement (Second) of Trusts § 187 cmt. d (1959)).

In the First Circuit, all challenges to a conflicted administrator's decision are reviewed under the arbitrary-and-capricious standard, for which the "basic touchstone" is reasonableness. *See Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57 (1st Cir. 1999). And, as part of this inquiry, courts are to consider whether an administrator of a plan who is also the insurer stands to lose money by paying a claim. *See id.* ("Any reviewing court is going to be aware that in the large, payment of claims costs [an insurer] money."). The Second Circuit's approach is in accord: when an administrator is also a plan insurer and there is no evidence that this structural conflict has actually influenced a discretionary benefits determination, the determination is reviewed for abuse of discretion but the conflict of interest is "a factor to be weighed 'in determining whether there has been an abuse of discretion.'" *Pulvers v. First UNUM Life Ins. Co.*, 210 F.3d 89, 92 (2d Cir. 2000) (quoting *Sullivan v. LTV Aerospace & Defense Co.*, 82 F.3d 1251, 1255 (2d Cir. 1996)).

Most of the courts of appeals—the Third, Fourth, Fifth, Eighth, and Tenth—use a "sliding scale" approach to determine the appropriate level of arbitrary-and-capricious review to afford discretionary benefits decisions made by a conflicted administrator. *See Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 392 (3d Cir. 2000); *Doe v. Group Hospitalization & Med. Svcs.*, 3 F.3d 80, 87 (4th Cir. 1993); *Vega v. National Life Ins. Svcs., Inc.*, 188 F.3d 287, 297 (5th Cir. 1999) (*en banc*); *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1161-62 (8th Cir. 1998); *Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 826-27 (10th Cir. 1996).[5] Under this

[5] Reliance does not include the Eighth Circuit as among the courts of appeal that use a sliding-scale approach. Pet. 14. In *Woo*, however, the

approach, the administrator's structural conflict is one of several factors to be considered in shaping the scope of arbitrary-and-capricious review.[6] Though the sliding-scale approach is articulated differently than the approaches used in the First and Second Circuits, there is no difference in practical effect as applied to an administrator, such as Reliance here, whose structural conflict is not accompanied by independent evidence of actual bias. Under all of these approaches, the administrator's structural conflict of interest is simply a "factor" to be considered, alongside other case-specific factors, in conducting a review under the flexible arbitrary-and-capricious standard.

The remaining courts uniformly—and unsurprisingly—hold that an administrator's structural conflict of interest, standing alone, is a factor to be considered in an arbitrary-and-capricious review of a discretionary decision to deny benefits. The Sixth Circuit has held that an administrator's structural conflict of interest "'should be taken into account as a factor in determining whether the . . . decision was arbitrary and capricious.'" *Peruzzi v. Summa Med. Plan*, 137 F.3d 431, 433 (6th Cir. 1998) (quoting *Davis v. Kentucky*

Eighth Circuit made clear that "[b]ased on our review of *Firestone*, we adopt the 'sliding scale' approach." 144 F.3d at 1161.

[6] *See Pinto*, 214 F.3d at 393 (sliding scale approach requires courts "to consider the nature and degree of apparent conflicts with a view to shaping their arbitrary and capricious review of the benefits determinations of discretionary decisionmakers"); *Doe*, 3 F.3d at 87 ("[A] conflict of interest environment is . . . a factor to be considered in determining whether authorized discretion has been abused."); *Vega*, 188 F.3d at 297 ("The existence of a conflict is a factor to be considered in determining whether the administrator abused its discretion in denying a claim."); *Chambers*, 100 F.3d at 827 (administrator's conflict is "merely a factor in applying this flexible [arbitrary and capricious] standard"); *see generally Woo*, 144 F.3d at 1161 ("The abuse of discretion standard is inherently flexible, which enables reviewing courts to simply adjust for the circumstances.").

Fin. Cos. Retirement Plans, 887 F.2d 689, 694 (6th Cir. 1989)); *Cochran v. Trans-General Life Ins. Co.*, 12 Fed. Appx. 277, 281 (6th Cir. 2001) (noting that the existence of a conflict "shapes application of" the arbitrary-and-capricious standard of review). The Seventh Circuit was the first court of appeals to articulate the notion of a sliding-scale of arbitrary-and-capricious review—the same standard used by the Third and most other circuit courts of appeals—and has used this approach to apply "careful" arbitrary-and-capricious review to a decision by an administrator who operated under a structural conflict of interest.[7] *See Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1052-53 (7th Cir. 1988) (Posner, J.) (review under the sliding scale of arbitrary-and-capricious review is "more penetrating the greater is the suspicion of partiality, less penetrating the smaller that suspicion is").

Admittedly, the Ninth Circuit—like the Second Circuit—conducts a *de novo* review when a claimant shows that an administrator's conflict of interest actually influenced its benefits determination. *See Nord v. Black & Decker Disability Plan*, 296 F.3d 823, 831 (9th Cir. 2002), *rev'd on other grounds*, 123 S. Ct. 1965 (2003). But where, as here, there is no finding that the conflict has actually influenced an administrator's decision, the Ninth Circuit, like all of the

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[7] Reliance does not include the Seventh Circuit among the courts that use the sliding-scale approach. Pet. 13. But, as several other courts of appeals have noted—citing *Van Boxel* as authority—the Seventh Circuit also uses the sliding-scale approach. *See Fought v. UNUM Life Ins. Co.*, 357 F.3d 1173, 1181-82 (10th Cir. 2004); *Vega*, 188 F.3d at 296; *Travelers*, 167 F.3d at 57 n.2. Reliance cites to the Seventh Circuit's later panel decision in *Mers v. Marriott International Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014 (7th Cir. 1998), as indicating that the Seventh Circuit uses a different approach. At best for Reliance, however, *Mers* indicates only that the issue is still percolating in the Seventh Circuit. *But see Horwitz v. Alloy Auto. Co.*, 992 F.2d 100, 103 (7th Cir. 1993) ("not in the cards" for a later panel to overrule a prior panel decision).

other circuit courts including the Second Circuit, takes the structural conflict of interest into account when conducting a review under the arbitrary-and-capricious standard. *See Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., Inc.*, 125 F.3d 794, 797 (9th Cir. 1997) ("Given [the insurer's] dual role as both the funding source and the administrator of the Plan, we are faced with an inherent conflict of interest situation, and must take this factor into account."). Finally, the Eleventh Circuit reviews an insurer's discretionary benefits determination under the arbitrary-and-capricious standard and allows this standard to be "shaped by the circumstances of the inherent conflict of interest." *Brown v. Blue Cross & Blue Shield of Alabama, Inc.*, 898 F.2d 1556, 1563 (11th Cir. 1990); *see also Levinson v. Reliance Std. Life Ins. Co.*, 245 F.3d 1321, 1326 (11th Cir. 2001) (arbitrary-and-capricious standard is "heightened" in reviewing discretionary determinations made by conflicted administrators in that the "standard 'must be contextually tailored' to the case") (quoting *Brown*, 898 F.2d at 1563-64).

Of course, not all courts of appeal articulate the standard using the exact same words. The administrator's structural conflict of interest is taken into account as a "factor," *see, e.g.*, *Pinto*, 214 F.3d at 392, *Doe*, 3 F.3d at 87; something that "shapes" the review, *see, e.g.*, *Cochran*, 12 Fed. Appx. at 281; to "adjust" for, *see, e.g.*, *Woo*, 144 F.3d at 1161; or to be "aware" of, *see, e.g.*, *Travelers Ins. Co.*, 167 F.3d at 57, when reviewing a discretionary determination that a claimant is ineligible for benefits and there is no evidence that the determination is tainted by bias. But these slight variations in phrasing all amount to the same fundamental approach. In *all* circuits, the administrator's structural conflict is treated as something that a court should consider, in conjunction with all of the other evidence, in determining whether the administrator's discretionary decision to deny benefits is arbitrary and capricious. There is no point in the Supreme Court taking this case to resolve a non-existent "conflict"

regarding what precise words should be used to describe what amounts to the same approach to conducting arbitrary-and-capricious review.

Reliance has strained to identify a conflict, but it has no bearing on this case. As noted, the courts of appeal use different approaches for determining what standard of review applies to an administrator's discretionary decision to deny disability benefits when—unlike in the present case—the administrator's conflict of interest is accompanied by proof that its decision reflected actual bias. *Compare, e.g., Sullivan*, 82 F.3d at 1256 (*de novo* review if evidence shows that administrator's decision was influenced by the conflict), *and Black & Decker*, 296 F.3d at 829 (same, if administrator cannot rebut the showing that conflict influenced its decision), *with Vega*, 188 F.3d at 296-97 (sliding scale). But that issue is simply not presented here. The district court expressly determined that Reliance did not exhibit any bias in denying Dr. Lasser's disability benefits claim. Pet. App. 41a-42a. Neither party challenged this determination on appeal, the Third Circuit did not review it (*id.* at 9a), and indeed Reliance would have no interest in *heightening* the standard of review. This case is thus not a suitable vehicle for determining the proper standard of review where an administrator's structural conflict of interest is accompanied by proof of actual bias.

II. THE CASE-SPECIFIC QUESTION OF WHETHER RETURNING TO WORK IS DISPOSITIVE EVIDENCE OF NON-DISABILITY IS ALSO NOT CERT-WORTHY

Reliance also urges review of "whether evidence that a claimant has returned to work may be taken into account in making disability determinations." Pet. 17. Reliance says that there is "tension" among the courts of appeals on this issue, but the differences in outcomes in the cases cited are attributable to straightforward, case-specific differences in the disability insurance policies at issue.

In this case, the Third Circuit rejected Reliance's argument that Dr. Lasser's return to work and resumption of on-call and emergency care duties "settles" whether he is disabled. Pet. App. 20a. Reliance cites two cases as "[c]ontrary to the Third Circuit's approach" (Pet. 17): *Galman v. Prudential Insurance Co.*, 254 F.3d 768 (8th Cir. 2001), and *Deegan v. Contintental Casualty Co.*, 167 F.3d 502 (9th Cir. 1999). Both cases turned on policy-specific definitions of "disability" which made it clear that a claimant could not be deemed disabled if she was working in any capacity. In *Galman*, a claimant who resumed working after suffering a heart attack could not claim he was disabled because the definition of "total disability" required that the claimant was "not working at any job." 254 F.3d at 771. Likewise, in *Deegan*, the policy defined "total disability" as, among other things, "not gainfully employed in any occupation for which [the insured] is or becomes qualified." 167 F.3d at 504. Given this language, the Ninth Circuit ruled that a claimant who had resumed full-time work was no longer eligible for disability benefits. *See id.* at 509.

Unlike the policies at issue in *Galman* and *Deegan*, the policy at issue here does not address whether an insured who returns to work may claim disability benefits.[8] The district court thus rejected Reliance's blunt argument that "[t]he fact [Dr. Lasser] was working proved that he was no longer disabled." Pet. App. 53a (quoting Reliance's brief). The court instead relied on case-specific evidence that Dr. Lasser was disabled due to his heart condition and that, although he had returned to on-call and emergency duties out of economic necessity, the added stress of performing these

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[8] An insured is deemed disabled under the policy at issue here if he "cannot perform the material duties of his[] regular occupation" as a result of an injury or sickness. An insured is also deemed disabled under the policy if he "is capable of performing the material duties of his[] regular occupation on a part-time basis or some of the material duties on a full-time basis." Pet. App. 42a.

duties posed an undue risk to his health. *Id.* at 54a. As noted, the Third Circuit agreed. *Id.* at 20a. The Court of Appeals likewise relied on the record evidence which showed that, to whatever extent Dr. Lasser had been performing on-call and emergency surgery duties, "he [was] doing so to his detriment" and against medical advice. *Id.* The Third Circuit's holding thus was not, as Reliance characterizes it, that "*as a matter of law*, an insurer may not consider evidence of a claimant's return to work in making an eligibility determination." Pet. 19 (emphasis in original). The Third Circuit instead determined only that, on the specific facts of this case, Reliance could not consider Dr. Lasser's return to work as dispositive evidence that he was not disabled.[9]

The circuit split that Reliance claims to have identified is thus illusory. Not surprisingly, none of the cases cited by Reliance holds that a claimant's return to work is, in the abstract, "dispositive" evidence that he is disabled. Each federal appellate court to have addressed the probative value of a claimant's return to work has done so on a case-by-case basis according to the particular terms of the disability

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[9] The remaining cases cited by Reliance on this issue—*Hawkins v. First Union Corp. Long-Term Disability Plan*, 326 F.3d 914 (7th Cir. 2003), and *Levinson v. Reliance Standard Life Insurance Co.*, 245 F.3d 1321 (11th Cir. 2001)—do not stand for the proposition that a claimant's return to work is immaterial to a disability benefits determination. In *Hawkins*, the Seventh Circuit rejected the insurer's argument—similar to Reliance's argument here—that an insured's return to work means that, as a matter of law, "he cannot be disabled." 326 F.3d at 918. The only other case Reliance cites is the Eleventh Circuit's decision against Reliance in *Levinson v. Reliance Standard Life Insurance Co.* But, as Reliance concedes (Pet. 19), the Eleventh Circuit did not even reach the issue of whether an insurer may consider evidence of a claimant's return to work in making a disability determination because, as in this case, there was evidence that the claimant could not in fact perform the material duties of his job on a full-time basis. *See Levinson*, 245 F.3d at 1326 n.6.

insurance policy at issue and other, case-specific evidence of a claimant's disability. The issue is, at bottom, a case-by-case matter of construing disability insurance policy terms and evaluating all of the evidence of a claimant's disability. It does not merit this Court's attention.

CONCLUSION

The petition for a writ of certiorari should be denied in its entirety.

Respectfully submitted,

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April 23, 2004

APPENDIX

IN THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

STEPHEN P. LASSER,	)	
	)	
Appellee,	)	
	)	
v.	)	**No. 02-4123**
	)	
RELIANCE STANDARD LIFE INSURANCE COMPANY,	)	
	)	
	)	
Appellant.	)	
	)	

APPELLANT'S PETITION FOR REHEARING
AND/OR REHEARING EN BANC

Statement of Counsel

I express a belief, based on a reasoned professional judgment, that the decision of the majority panel conflicts with a decision of the Supreme Court of the United States of America. Specifically, the majority panel held that "once a claimant makes a *prima facie* showing of disability through physicians' reports. . . , and if the insurer wishes to call into question the scientific basis of those reports. . . , then the burden will lie with the insurer to support the basis of its objection." See Opinion at p. 15. This statement is in direct conflict with the decision by the Supreme Court in *Black & Decker Disability Plan v. Nord*, 123 S. Ct. 1965 (2003), wherein the Court held that "courts have no warrant to require administrators automatically to accord special weight to the opinions of a claimant's physician; nor may courts impose on plan administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation."

The majority opinion also conflicts with the law of this Circuit regarding the manner in which the court should review a plan's decision under the heightened arbitrary and capricious standard. As stated in the dissenting opinion, "the majority discusses the evidence as if it was subjected to *de novo* review after trial. In doing so, it draws its own conclusion and substitutes its own judgment as to who and what is to be believed." See dissenting opinion at p. 24. This is inconsistent with the heightened arbitrary and capricious standard of review. *See Pinto v. Reliance Standard Life Insurance Co.*, 214 F.3d 377, 393 (3d Cir. 2000); *Orvosh v. Program of Group Ins. for Salaried Employees*, 222 F.3d 123, 129 (3d Cir. 2000).

/s/
Joshua Bachrach, Esquire

Introduction

On September 18, 2003, a majority panel of this court issued a Precedential Opinion affirming the decision of the district court in favor of the plaintiff. Dissenting from the majority's decision was Circuit Judge Garth. The underlying action involves a claim for disability benefits under an employee benefit plan that is governed by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001 *et seq*.

Factual Background

Plaintiff-Appellee Stephen Lasser, M.D. is an orthopaedic surgeon. (JA 195). On July 16, 1996, Dr. Lasser developed chest pain and shortness of breath. (JA 195). He was subsequently diagnosed as having an acute myocardial infarction for which he underwent cardiac catheterization and stenting. (JA 205). A subsequent thallium stress test revealed that it was a "very small myocardial infarction" which the cardiologist described as "probably clinically insignificant." (JA 208).

Within a few weeks, Dr. Lasser had returned to work part-time, including office visits and elective surgery. (JA 209). His doctor told Reliance Standard that "by all objective criteria Dr. Lasser is doing very well at this point in time. He does not currently have symptoms." (JA 222).

None of the doctors who evaluated Dr. Lasser stated that he could not work full-time. Instead, his disability was based on his claim that he could not perform on-call or emergency services. Accordingly, Reliance Standard performed a vocational investigation to determine whether these were "material duties" of Dr. Lasser's occupation. Based on the results of the investigation, Reliance Standard concluded that they were not. (JA 235; 237). Dr. Lasser failed to submit any vocational evidence to contradict these findings. See Opinion at p. 23.

Based on its investigation, Reliance Standard concluded that Dr. Lasser was not totally disabled. Significantly, during Reliance Standard's adjudication of the claim, and contrary to his claimed disability, Dr. Lasser returned to his regular work schedule, *including* emergency services and on-call responsibilities. (JA 263).

Procedurally, this ERISA action was pending in the United States District Court for the District of New Jersey and assigned to the Honorable Alfred M. Wolin. Following the entry of a final order against it, Reliance Standard filed a timely appeal. On appeal Reliance Standard argued that:

> (1) Dr. Lasser cannot be considered disabled since he returned to his "regular" work; (2) the evidence did not support the conclusion of the district court that the denial of benefits was an abuse of discretion; and (3) the district court failed to properly apply the heightened arbitrary and capricious standard of review.

On April 24, 2003, oral argument was held before Chief Judge Scirica and Circuit Judges Ambro and Garth. On

September 18, 2003, the court issued a Precedential Opinion affirming the decision of the district court. The majority opinion was written by Judge Ambro in which he was joined by Chief Judge Scirica. A dissenting opinion was filed by Judge Garth.

Argument

A. The Majority Panel Adopted The "Treating Physician Rule" Contrary To The Decision of the Supreme Court in *Black & Decker Disability Plan v. Nord.*

On May 27, 2003, after oral argument was held in this case but prior to the filing of the Opinion, the Supreme Court issued its decision in *Black & Decker Disability Plan v. Nord*. At issue in *Nord* was whether the treating physician rule applies to disability claims under ERISA. Under the treating physician rule, ERISA plan fiduciaries were required to "accord special deference to the opinions of treating physicians." *Nord*, 123 S.Ct. at 1967.

The Court held that the treating physician rule may *not* be used in ERISA cases. Specifically, the court stated:

> . . . we hold, Courts have no warrant to require administrator automatically to accord special weight to the opinions of a claimant's physician; nor may Courts impose on plan administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation.

Id.

In this case, the majority's discussion of "the burden of proof in disability cases" is in conflict with the law as stated in *Nord*. According to the majority, if the plan insurer does not accept the opinions stated in the claimant's physicians' reports, "then the burden will lie with the insurer to support the basis of its objection." See Opinion at p. 15. While the

court did not describe this as the treating physician rule, its effect is the exact same. The majority holding is contrary to the Supreme Court's admonition that courts may not impose on disability plans "a discrete burden of explanation" when they disagree with the opinion of a treating physician. *See Nord, supra.*

A sufficient basis for rehearing exists based on the conflict between the majority's decision and *Nord.* It is also worth noting, however, that the majority's decision also conflicts with the law of this Circuit. In *Pinto v. Reliance Standard Life Insurance Co.*, 214 F.3d 377, 394 n.8 (3d Cir. 2000), the Third Circuit emphasized that its discussion of the heightened arbitrary and capricious standard "should not be read to require an additional duty to conduct a good faith, reasonable investigation." *See also Foley v. Intern. Broth. Elec. Workers*, 271 F.3d 551, 559 n.9 (3d Cir. 2001)(claimant bears the burden of proof that the plan acted arbitrarily and capriciously).

B. The Majority Failed to Follow The Precedent of This Circuit in Its Analysis.

The dissenting opinion of Judge Garth correctly states the law to be followed by courts when reviewing a plan's decision under the arbitrary and capricious standard. Under this deferential standard, neither the district court nor the Court of Appeals may substitute its own judgment for that of the plan fiduciary. See Opinion at p. 18. *See also Abnathya v. Hoffmann-LaRoche, Inc.*, 2 F.3d 40, 41 (3d Cir. 1993). A decision is not arbitrary and capricious if there is evidence that might support the opposite conclusion. *Id.* A decision is only arbitrary if it is "clearly not supported by the evidence in the record." *Id. See also Orvosh*, 222 F.3d at 129.

As the majority concedes, the district court failed to follow the law of this Circuit when it relied on the Ninth Circuit's decision in *Kearney v. Standard Ins. Co.*, 175 F.3d 1084 (9th Cir. 1999), and made *de novo* findings of fact. See Opinion at p. 5 n. 3. However, according to the majority, the

district court's application of the incorrect law was not reversible error since the court limited itself to the evidence that was before Reliance Standard. *Id.* A court's review is not deferential simply because the court limits itself to the administrative record. In fact, the court in *Kearney* also limited itself to the administrative record when it conducted its *de novo* review of the claim decision.

As recognized by Judge Garth, the majority "has fallen into the same pattern of analysis employed by the District Court. Instead of addressing and assessing the basis, the rationale and the evidence which led to the Administrator's determination denying benefits, and then giving appropriate deference to that determination, the majority discusses the evidence as if it was subjected to *de novo* review after trial. In doing so, it draws its own conclusions and substitutes its own judgment as to who and what is to be believed." See Opinion at pp. 23-24. This type of analysis is not allowed under the law of this Circuit. *See Abnathya, supra.*

Contrary to the majority's conclusion, there is substantial evidence in this case supporting the denial of benefits. See dissenting opinion at p. 26. This evidence includes the fact that Dr. Lasser returned to full-time, unrestricted work, including on-call and emergency services while still claiming that he was disabled. (JA 263).

In its initial brief, Reliance Standard cited to several ERISA decisions in which courts found that disability plans properly denied benefit claims based on the claimant's demonstrated ability to work. *See Deegan v. Continental Casualty Co.*, 167 F.3d 502, 507 (9th Cir. 1999); *Galman v. Prudential Insurance Co. of America*, 254 F.3d 768 (8th Cir. 2001); *Davidson v. Liberty Mutual Insurance Co.*, 998 F. Supp. 1, 10 (D. Me. 1998); *Wesley v. Montsanto Co.*, 554 F. Supp. 93 (D. Mo. 1982), *aff'd*, 710 F.2d 490 (8th Cir. 1983).

In support of its conclusion that Dr. Lasser's return to work was not dispositive of his disability claim, the majority cites to two ERISA decisions which, upon review, do not

support that conclusion. In *Hawkins v. First Union Corp. Long-Term Disability Plan*, 326 F.3d 914 (7th Cir. 2003), the claimant worked for a number of years with his condition before he claimed disability. The Seventh Circuit stated that the claimant may have forced himself to continue to work before the pain and fatigue became too much. *Hawkins*, 326 F.3d at 918. By contrast, Dr. Lasser returned to work while still claiming that he was still disabled. The claimant in *Levinson v. Reliance Standard Life Ins. Co.*, 245 F.3d 1321 (11th Cir. 2001) claimed that he had not returned to his prior full-time work while seeking benefits. Unlike these cases, the cases relied on by Reliance Standard are directly on point and dispositive of the claim.

The majority improperly substituted its own judgment for that of Reliance Standard when it dismissed the significance of Dr. Lasser's return to work. See Opinion at p. 16. In fact, the majority even questioned whether Dr. Lasser had returned to his prior job activities even though this was confirmed in the medical records. See Opinion at p. 16. Rather than deferring to Reliance Standard on this point as it was required to do under the law, the majority stated that "this issue involves a factual question that we do not resolve on appeal." This statement is inconsistent with the applicable law.

A major issue in this claim and on appeal was whether emergency and on-call work are material duties of Dr. Lasser's regular occupation. Supporting Reliance Standard's conclusion that these were not material duties were the DOT and a labor market survey. See Opinion at p. 22. As stated by Judge Garth, "[a]ll of this evidence stands unrebutted by Dr. Lasser." See Opinion at p. 23. Thus, Dr. Lasser failed to meet his burden since he "submitted no evidence, no proofs, no affidavits, no witnesses, and no depositions on the issue of materiality." See Opinion at p. 21.

The majority substituted its own judgment and "gave no deference whatsoever" to Reliance Standard in its review of

the vocational issues. See dissenting opinion at p. 22. Without any evidence offered by Dr. Lasser to contradict the DOT and the labor market survey, the majority nevertheless concluded that Reliance Standard abused its discretion. The majority stated that it was unreasonable for Reliance Standard to rely on the DOT since "the DOT's silence about this critical issue [of whether on-call and emergency services are material duties] makes the DOT unhelpful. . ." See Opinion at p. 9 n. 5. Contrary to this conclusion of the majority and the district court, the DOT only identifies material duties. Therefore, the fact that it does not include on-call and emergency services is substantial evidence that they are *not* material duties.

As stated in the dissent, and contrary to the majority's conclusion, the DOT "is a recognized authority in the vocational industry." See Opinion at p. 22 *citing Gallagher v. Reliance Standard Life Ins. Co.*, 305 F.3d 264, 272-73 (4th Cir. 2002). *See also Dionida v. Reliance Standard Life Ins. Co.*, 50 F. Supp.2d 934, 939 (N.D. Cal. 1999). ("Given the amount of research and analysis that has gone into grouping similar jobs and defining the occupational titles, and the length of time the D.O.T. has been widely used, it is reasonable for plan administrators and courts to use it for determining a claimant's 'regular occupation"); *Winters v. Uum Life Insurance Co.*, 232 F. Supp. 2d 918, 931 (W.D. Wis. 2002) (referring to the Dictionary of Occupational Titles to define the claimant's occupation). When the majority disregarded the DOT when it was faced with no contrary evidence, it substituted its own judgment for that of Reliance Standard. This is improper under Third Circuit law.

The majority also substituted its own judgment for that of Reliance Standard by disregarding the results of the vocational study. As Judge Garth remarked, "the use of such vocational studies in eligibility for disability benefits is an accepted practice in this Circuit." See Opinion at p. 23, *citing Russell v. Paul Revere Life Ins. Co.*, 288 F.3d 78, 79 82 (3d

Cir. 2002). Contrary to the majority's conclusion and as stated by Judge Garth, it was not unreasonable for Reliance Standard to conclude that on-call and emergency services were not material based on the survey and the fact that Dr. Lasser failed to provide a contrary vocational opinion. *Id.*

According to the majority, "Dr. Lasser's regular occupation was as an orthopaedic surgeon responsible for emergency surgery and on-call duties in a relatively small practice group and within a reasonable travel distance from his home in New Jersey." See Opinion at p. 6. This was not Dr. Lasser's "regular occupation." Instead, this was his *job* and the Reliance Standard policy only pays a benefit when a claimant is unable to perform the duties of his "regular occupation," not his job. *See Ehrensaft v. Dimension Works Inc. Long Term Disability Plan*, 120 F.Supp.2d 1253, 1258-1259 (D. Nev. 2000)("the term, 'occupation,' is a general description, not a specific one. . . A person may not be able to perform a specific job assignment, but still be able to perform the duties generally understood to be part of his or her 'occupation.'); *Hanser v. Ralston Purina Co.*, 821 F. Supp. 473, 478 (E.D. Mich. 1993).

In support of its narrow interpretation of the term "regular occupation," the majority cites to *O'Bryhim v. Reliance Standard Life Ins. Co.*, 188 F.3d 502 (Table), 1999 W.L. 617891 (4th Cir. 1999). *O'Bryhim* is an unpublished decision and is no longer valid law in the Fourth Circuit. In the more recent published decision in *Gallagher* the Fourth Circuit stated that it was reasonable for Reliance Standard to rely on the DOT to define the material duties of the claimant's regular occupation. *See Gallagher*, 305 F.3d at 271. Of equal significance, the Fourth Circuit reached this conclusion while reviewing the plan's decision *de novo* whereas the majority in this case was required to give deference to the Reliance Standard.

The majority also relied on *Kinstler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243 (2d Cir. 1999). *Kinstler*

also does not support such a narrow interpretation. *Kinstler* only required consideration of a position "of the same general character as the insured's previous job." *See Kintsler*, 181 F.3d at 252-253. More important, as recognized by Judge Garth but ignored by the majority, the court's review in *Kinstler* was *de novo* unlike this case. See Opinion at p. 24.

Contrary to the majority's holding, on-call and emergency services cannot be considered material duties of Dr. Lasser's regular occupation. Dr. Lasser's regular occupation involves performing orthopaedic surgery. Whether he performs these activities on-call or during regularly scheduled office hours, the duties are the same. Therefore, the time when these duties are performed cannot be considered a material duty itself. *See Ceasar v. Hartford Life and Accident Insurance Co.*, 947 F. Supp. 204, 207 (D. S.C. 1996)(plaintiff claiming he was disabled since his employer required rotating shifts which aggravated his sleep apnea was not entitled to benefits since a labor market survey found that the occupation could be performed for other employers without the requirement of rotating shifts); *Dym v. Provident Life and Accident Insurance Co.*, 19 F. Supp.2d 1147 (S. D. Cal. 1998) (gynecological surgeon whose prior practice involved on-call and emergency surgeries was not totally disabled even though he worked less hours following an accident).

The majority also relied on the decline in Dr. Lasser's earnings in support of its conclusion that on-call and emergency services were material duties. However, the majority admittedly guessed at what Dr. Lasser might earn if he worked forty hours per week. See Opinion at p. 9. The majority could only assume what Dr. Lasser might earn as there was no evidence in the record on this subject. This further demonstrates that the majority improperly arrived at its own factual conclusions rather than looking to whether Reliance Standard's decision was reasonable as it was required to do under the law.

Finally, the majority substituted its own judgment for that of Reliance Standard when it placed too great a weight on the potential risk of future harm due to stress from on-call and emergency services. This should not have even been a concern because, as stated by Judge Garth, by working unrestricted after disability benefits were discontinued, Dr. Lasser failed to satisfy "the policy's condition of inability to perform tasks material to his occupation. . ." See Opinion at p. 25.

In contrast to the majority's position, Judge Garth's conclusion is supported by ample case law. *See Galman v. Prudential Ins. Co. of America*, 254 F.3d 768 (8th Cir. 2001); *Gooden v. Provident Life & Acc. Ins. Co.*, 250 F.3d 329 (5th Cir. 2001); *Coker v. Metropolitan Life Ins. Co.*, 281 F.3d 793 (8th Cir. 2002). In each of these cases, the claimants suffered from heart disease and their doctors stated that they risked further damage by returning to work. In each of these cases the courts concluded that it was not arbitrary and capricious to deny the claims since the claimants were currently capable of working. The facts in this case are even more compelling against a finding of disability since Dr. Lasser did return to work.

Judge Garth identified the real issue in this case and why Dr. Lasser should not prevail as follows:

> Reliance's policy does not insure against *future* disability, only *present* disability. A doctor or other expert who determines that a patient is disabled based on the possible *future* affects of stress should have to quantify that risk so that the ERISA decision maker can determine if it constitutes a present disability. Thus, an opinion that Dr. Lasser's venous graft may not survive another five years does not satisfy the condition of Reliance's disability policy, a policy which requires that Dr. Lasser be

> unable to perform the material duties of his occupation at this time.

See Opinion at pp. 26-27. Here, Dr. Lasser's doctors failed to even quantify the risk of future harm. See Opinion at p. 26. Once again, the majority substituted its own judgment for that of Reliance Standard when it stated that it was not necessary for the doctors to quantify the future risk. See Opinion at p. 15 n.12.

Based on the foregoing, Reliance Standard Life Insurance Company respectfully requests rehearing by the panel or in the alternative rehearing *en banc*.

By: /s/
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